Memorandum

To: Chris Koller and Gary Alexander, Co-Chairs
Community Hospital Task Force

From: Kevin Quinn and Connie Courts

Date: January 3, 2008

Re: Overview of Outpatient Payment Issues

As requested at the December 19 task force meeting, this memo and the attached document provide information about Medicaid payments for outpatient hospital care. The question was asked in the context of outpatient payment being a topic worthy of Task Force consideration at a later date.

In FY 2007, Medicaid fee-for-service payments for outpatient care were approximately $62 million, excluding Medicaid payment on Medicare crossover claims. RIte Care payments were an additional $72 million. These figures include emergency department payments of $16 million and $24 million, respectively. (All figures are approximate, since we did this analysis several months ago.)

On the fee-for-service side, the current payment method dates largely from 1971, just as the inpatient payment method does. Each summer Medicaid and the hospital industry negotiate the Maxicap, which is the percentage increase in allowable costs that is applied (in practice) uniformly across hospitals. During the year, claims are paid at a percentage of charges, with different percentages used for surgical and non-surgical care. After the end of the year, a settlement process results in payments to or from each hospital to bring the interim payments into line with the negotiated budgets. For many years, the only exceptions to cost-based payment were lab services, which are paid using a fee schedule, without year-end settlement. In 2006, the Department extended the fee schedule approach to imaging services. Out-of-state hospitals are paid percentages of charges, without year-end settlement.

The RI Medicaid method is quite similar to the methods traditionally used by other states. These methods have various disadvantages, however, leading quite a few states to consider adopting new ways of calculating payment. The two leading alternatives are based on Ambulatory Payment Classification (APC) groups and Ambulatory Patient Groups (APGs). Medicare and several Medicaid programs use APCs, while several Medicaid programs and other payers use APGs. The attached backgrounder provides further information on the history of outpatient payment, Medicaid concerns with traditional payment methods, and the alternatives.

We would be pleased to provide any further information that may be useful.